INDIVIDUAL SUPPORT PLAN (ISP)

INSTRUCTION MANUAL

(NOVEMBER, 2006)

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PURPOSE OF THE INDIVIDUAL SUPPORT PLAN (ISP) MANUAL

The purpose of the Individual Support Plan (ISP) instruction manual is to assist Plan Developers in completing all of the forms required for an ISP. Each of the following forms must be typed and submitted to the Idaho Center for Disabilities Evaluation (ICDE), before an initial or annual ISP can be processed for authorization:

- ISP Supports and Services Authorization form
- Personal Summary form
- ISP Supports and Services form
- ISP "Signature" Page form
- Health and Well-Being Checklist
- Extenuating Circumstances form (if applicable)

For **Annual ISPs**, the following documents must <u>also</u> be submitted:

- Provider Status Reviews
- Plan Monitor Summary
- Program Implementation Plan

For **ISP Addendums**, <u>only</u> the following documents must be submitted:

- ISP Supports and Services Addendum form
- Extenuating Circumstances form (if applicable)

IMPORTANT: Before submitting the forms listed above, a Plan Developer should ensure the following requirements have been met:

- **All forms must be typed**
- **All fields within the forms must be completed.**

<u>Forms that do not comply will be returned to the Plan Developer</u>.

ISP SUPPORTS AND SERVICES AUTHORIZATION

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Developer.

Instructions:

Date ISP completed: Month, day and year of Person-Centered Planning (PCP) meeting.

Initial Plan: Check this box if this is the first Individual Service Plan (ISP) being submitted for the participant.

Annual: If this is not an Initial Plan, check this box.

Waiver Participant: Check the "yes" or "no" box according to waiver status.

Medicaid Number: First seven digits of the participant's Medicaid identification number as listed on Idaho Medicaid card.

Participant Name: Name of participant exactly as it appears on the Medicaid card.

PD: First and last name of the Plan Developer.

Waiver Participant Initials: Participant must indicate by initialing that they have chosen waiver services over ICF/MR placement. If participant is unable or unwilling to sign, the Plan Developer must indicate the reason(s) why.

If there is a guardian, the guardian must initial that they have chosen waiver services over ICF/MR placement for the participant.

Service Provider: List in the appropriate section all Waiver and State Plan service providers who are delivering services to the participant. All routine costs that support a participant in the community must be listed.

Waiver and State Plan services are as follows:

> **Waiver:** Residential Habilitation—Supported Living, Residential Habilitation—Certified Family Home, Residential Habilitation—Agency Affiliation, Chore Services, Respite Services, Community Supported Employment (CSE), Non-Medical Transportation, Environmental Accessibility Adaptations, Specialized Medical Equipment, Personal Emergency Response Systems (PERS), Home-Delivered Meals, Nursing Services, Behavior Consultation/Crisis Management and Adult Day Care.
>
> **State Plan**: Plan Development, Plan Monitoring, Service Coordination and Developmental Disabilities Agency, Mental Health services, State Plan Personal Care Services (PCS), Occupational Therapy, Physical Therapy, Speech Therapy, Durable Medical Equipment, Medical transportation.

Service Type: Identify the formal or informal service delivered by the service provider (i.e. Developmental Disabilities Agency, Specialized Medical Equipment, etc.).

Proposed Start Date: Proposed start date for each service delivered.

Service Code: List the service code that corresponds with the Waiver or State Plan service. This service code can be found under the Procedure Code and Modifiers column of the most current DDA Reimbursement Rate Chart (see Appendix).

Units & Frequency of Service: This is a two-step process.

Step 1. To Determine **"Units"** refer to the "Medicaid Reimbursement Rate" column on the DD Reimbursement Rate Chart. In this column find the value associated with a **unit**.

Examples of units and their value are as follows:

- 1 unit=15 minutes,
- 1 unit= 1 day,
- 1 unit= 1 mile,
- 1 unit=1 time per month.

Based on the unit value determine the TOTAL number of units being requested for a particular service or support.

For example:

Transportation ⇨ If 1 unit = 1 mile and a transportation provider is requesting 50 miles of service, then 50 miles = 50 units and 50 would be the TOTAL number of units to request.

List the TOTAL number of units being requested in the "Units and Frequency of Service" column.

REMINDER: When a service provider is requesting hours of service, the number of hours requested must be multiplied by 4 to determine the total number of units.

Number of hours x 4 = Number of units

For example:

- 10 hours x 4 units per hour = 40 units

Step 2. To Determine **"Frequency"** identify how often the unit(s) of service are being delivered. List the **"Frequency"** along with the "Units" in the "Units & Frequency of Service" column.

For example:

- 1 unit/***daily*** (i.e. Supported Living: Daily rate)
- 40 units/***day*** (i.e. Supported Living: Hourly)
- 80 units/***week*** (i.e. Developmental Therapy)
- 1 unit/***month*** (i.e. Service Coordination)
- 3 units/***year*** (i.e. Developmental Evaluation)

- 50 units/***week*** (mileage)

Unit Cost: Refer to the "Medicaid Reimbursement Rate" column of the DD Reimbursement Rate chart for **unit** cost. In this column find the dollar value associated with a unit. List this dollar value in the "Unit Cost" column.

For example:

- H2032: 1 unit=$4.45

REMINDER: Do not use the hourly dollar value associated with a service code, only use the dollar value associated with a UNIT.

Annual Cost: Determine the Annual cost for a "Service Type" using this formula:

UNIT COST X NUMBER OF UNITS X FREQUENCY = ANNUAL COST

Determine the "Unit Cost", "Number of Units" and "Frequency" in the following manner:

- **UNIT COST:** As identified from the "Unit Cost" column for this service.
- **NUMBER OF UNITS:** As identified from the "Units and Frequency of Service" column for this service.
- **FREQUENCY:** The multiplier used for "Frequency" is based on how often a service is being provided (i.e. daily, weekly, monthly, one time or annually). Use the Frequency Formula below to determine the correct multiplier to use in your calculation:

Frequency Formula
Daily=365
Weekly=up to 52
Monthly= 12
One time or annually=1

For example:

UNIT COST X NUMBER OF UNITS X FREQUENCY = ANNUAL COST

$4.45 (unit cost) x 40 (number of units) x 52 (frequency) = $9,256.00 (annual cost)

Requires IPA #: For Department of Health & Welfare use only.

Medicaid Annual Total: Add the totals for both Waiver and State Plan services.

Participant Signature: The participant must sign in this section. If participant is unable or unwilling to sign, the Plan Developer must indicate reason(s) why.

Date (under participant signature line): Month, day and year participant signed ISP Supports and Services Authorization.

Guardian Signature: The guardian's signature on the Supports and Services Authorization page indicates the guardian's request for identified services on behalf of the participant. In the event the guardian is not physically present at the PCP meeting, documentation must exist which verifies the Plan Developer forwarded a copy of the entire ISP to the guardian for review.

If a Plan Developer is unable to obtain the guardian's signature prior to submitting the ISP for authorization, the Plan Developer has the option of obtaining confirmation from the guardian that they agree with the plan by e-mail or telephone. The Plan Developer must then document in the guardian signature section the guardian's approval of the plan, the means by which the Plan Developer received approval from the guardian (e-mail or telephone) and the date the approval was received.

Although the ISP may be submitted for authorization without the guardian's signature, when the above mentioned documentation is present, the Plan Developer must still require the guardian to sign, initial and forward a copy of the ISP Supports and Services Authorization page to the Plan Developer via mail or fax to support the request for services. The Plan Developer must then maintain the ISP Supports and Services Authorization page signed and initialed by the guardian in the participant's file for quality assurance review purposes.

Date (under Guardian signature line): Month, day, and year guardian signed ISP Supports and Services Authorization form OR the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP.

Plan Developer Signature: Signature of Plan Developer.

Date (under Plan Developer signature line): Month, day, and year Plan Developer signed ISP Supports and Services Authorization form

PERSONAL SUMMARY

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Developer.

Instructions:

Participant Name: Name of participant exactly as it appears on Idaho Medicaid card.

Medicaid Number: First seven digits of the participant's Medicaid identification number as listed on Idaho Medicaid card.

Gender: Male or female

Date of Birth: Month, day and year.

Current Status Instructions: For current status, describe each of the following areas as applicable. Keep your description to one page or less.

- Health: Identify primary and co-occurring diagnoses and health conditions (i.e. high blood pressure, allergies, specialized medical equipment. eye glasses and hearing aids, and/or devices, etc.).
- Living Situations: Indicate participant's current living situation (i.e. in their own home/apartment with or without roommates, Certified Family Home with or without relative providers, Residential Assisted Living Facilities (RALF).
- Religious Preference: Identify interest and involvement in church activities or spiritual practices.
- Family: Identify family member(s) or friends who are involved in participant's personal life.
- Behavioral Issues: Identify behavior(s) that would currently impact the participant's health and safety and the safety of others in the community.
- Employment: Identify where the participant works, what they do and whether it is paid or unpaid employment.
- Legal Status: Specify whether a participant is their own guardian or has a guardian. If the participant has a guardian, indicate first and last name of guardian and a contact telephone number. If a Durable Power of Attorney for Health Care has been assigned for the participant, please indicate the first and last name of the individual who has Durable Power of Attorney for Health Care for the participant and a contact telephone number.
- Communication: Indicate primary method of communication (i.e. verbal, sign language, communication devices or interpretive services, etc.).
- Mobility: Indicate adaptive equipment necessary for mobility and method(s) participant uses to navigate through the community (i.e. bicycles, family members, public transportation, drives own car, motorized wheelchairs, scooters, golf carts, etc.).
- Financial Status: Indicate representative payee or conservatorship, trusts, personal checking and/or savings account(s), sources of income, and participant's ability to manage own funds or if assistance is required.

Long-term goals: List the long-term goals as defined by the participant. Long-term goals are broader in nature and are used to guide the development of short-term goals to be addressed within the plan year as identified on the ISP Supports and Services page**.**

In other words, a direct relationship must always exist between the participant's long-term goals and the short-term goals listed on the ISP Supports and Services page.

Long-term goals and desires must enhance and/or maintain:

- Independence;
- Quality of life; and,
- Lead to greater choice and self-direction for the participant.

Assessed Need

An assessed need is a deficit that has been identified through objective testing and observation. It limits independent functioning, can be remedied through instruction or therapy, and is relevant to the participant's current situation.

Correlate Assessed Needs to Long-term goals: Identify each assessed need from the Personal Summary review. List each assessed need, one per line. For each assessed need, identify a long-term goal.

If an assessed need is low-priority for the participant and will not be addressed during the plan year, note this on the form in the Deferred Need section. You do NOT need to have a correlating goal and support/service for needs which will not be addressed. Indicate this along with the justification of the situation by a notation in the appropriate column of the form.

Each long-term goal which will be addressed during the plan year must have a correlating support or service on the Plan. Supports and services can be either paid or non-paid. An example of a completed Personal Summary Page is found in the Appendix, following the template.

ISP SUPPORTS AND SERVICES

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Developer.

Instructions:

Name: Name of participant exactly as it appears on Idaho Medicaid card.

Date of PCP Meeting: Month, day and year.

Supports and Services Column: Name the type of service and/or support being delivered to the participant. Services and supports should fall into one of the following categories:

- Formal services: Services are paid and have measurable objectives (i.e. supported living, DDA or CSE).
- Informal services: Services are paid but do not have measurable objectives (i.e. transportation, DME, etc.).
- Natural supports: Activities that are not paid and do not have measurable objectives (i.e. attend church with family member, play cards with neighbor, attend Special Olympics, participate in recreational activities, etc.).

Goals to be Addressed within the Plan Year. List at least one or more short-term goal(s) for each support or service the participant will be working on within the plan year.

Each goal listed on the form must be given its own identifier. This identifier must include both a number and a letter. This two-step process for assigning a number and letter is as follows:

Step 1. The **numbe**r used to identify the goal should correspond to the Life Quality Domain listed below, which best describes the general outcome associated with that goal.

Life Quality Domains and their corresponding numbers are as follows:

1 = Live a healthy lifestyle
2 = Obtain/maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

*For example: The goal of "Medication Management" would best be associated with the general outcome, "**Live a healthy lifestyle**", which is Life Quality Domain number "1".*

Therefore, the number used to identify the goal "Medication Management" would be "1", which corresponds to the Life Quality Domain ***"Live a healthy lifestyle"***.

Step 2. The **letter** of the alphabet used to identify a goal would depend on how many goals had been developed within each Life Quality Domain. Beginning with the letter "A", each separate goal within a particular Life Quality Domain must be assigned its own identifying letter (i.e. A, B, C . . . X, Y, Z).

For example: If under Life Quality Domain number "1", you have two (2) goals, "Medication Management" and "Meal Preparation", the first goal, "Medication Management" would be assigned the letter "A" along with its Life Quality Domain number of "1". Therefore, the first goal would be identified as follows:

1.A. Medication Management

and the second goal, "Meal Preparation" would be assigned the letter "B" along with its Life Quality Domain number of "1" . Therefore, the second goal would be identified as follows:

1.B. Meal Preparation

Below are additional examples of using both a number and a letter to identify a goal when you have more than one (1) goal listed for a particular Life Quality Domain:

- *7.A. Budgeting*
- *7.B. Money Skills*
- *2.A. Obtain Housing Assistance*
- *2.B. Obtain Energy Assistance*
- *2.C. Lawn Maintenance*

NOTE: This consecutive lettering system (A, B, C . . . X, Y, Z) must continue throughout the entire ISP Supports and Services form even if the goal(s) developed for a particular Life Quality Domain are for a different service or support provider. In other words, do not start over with the letter "A" each time you have a different service or support provider developing a goal if it is within the same Life Quality Domain.

IMPORTANT: Even if a particular Life Quality Domain contains only one (1) goal, that goal must still be identified using both a number and a letter.

Frequency Column: Frequency must identify how often a service or support is being delivered (i.e. daily, 10 hours/day, 20 hours/week, 5 days/week, 2 times/month, 1 time/year, 50 miles/week, etc.).

Reminders:

- If you are identifying the frequency of developmental therapy, also identify whether it is home and community-based *individual*, home and community-based *group*, center-based *individual* and/or center-based *group* developmental therapy

- For Durable Medical Equipment (DME), the quantity of the product must be identified in the frequency column (i.e. 3 boxes). If the product is also being requested on a regular basis (i.e. weekly, monthly), this information must also be included in this frequency column (i.e. 3 boxes *per week*, 1 case *per month*, etc.).

Agency or Provider Column: Identify the direct provider or agency responsible for providing the *formal or informal* service, and/or identify the name of the person or organization responsible for providing the *natural* support.

Start Date Column: If different than the proposed start date listed on the Personal Summary page, indicate the date on which the service or support is to be initially delivered.

NOTE: <u>NO</u> measurable objectives are to be listed on the "ISP Supports and Services" form. Measurable objectives are only listed on a participant's Implementation Plan.

INDIVIDUAL SUPPORT PLAN (ISP) "SIGNATURE" PAGE

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Developer.

Instructions:

Name: Name of participant exactly as it appears on Idaho Medicaid card.

Address: Current physical address, including city, state and zip code (Verify this is participant's current place of residence).

Telephone: Telephone number at which participant can be reached. Designate if number is for a land line, a cell phone or a message phone.

Date of Birth: Month, day and year.

Social Security Number: Nine-digit social security number.

Medicaid Number: First seven digits of the participant's Medicaid identification number as listed on Idaho Medicaid card.

Guardian (if applicable): First and last name of legal guardian.

NOTE: If a participant is committed to the Department of Health and Welfare, indicate that the Department is the guardian.

Guardian Address: Current mailing address. Include city, state and zip code.

Guardian Phone Number: Area code and telephone number at which guardian can be reached.

NOTE: If a guardian is named, verify that a copy of the guardianship papers are on file with the Idaho Center for Disabilities Evaluation (ICDE). If not, obtain guardianship papers and submit to ICDE.

Emergency contact: If no legal guardian is identified, include name, address and telephone number of a family member or friend who may be contacted in the event of an emergency.

Date of Person-Centered Planning Meeting (PCP): Month, day and year PCP meeting was conducted.

Initial Plan: Check this box if this is the first ISP being submitted.

Annual: If this is not an Initial ISP, check this box.

Healthy Connections: Check the "yes" or "no" box to indicate whether participant is enrolled in Healthy Connections. If you do not know if the participant is enrolled, call your local Healthy Connections representative for assistance. The numbers for each Region are as follows:

	Phone Number
Region I (Benewah, Bonner, Boundary, Kootenai, Shoshone Counties)	800-299-6766
Region II (Clearwater, Idaho, Latah, Lewis, Nez Perce Counties)	800-799-5088
Region III (Adams, Canyon, Gem, Owyhee, Payette, Washington Counties)	800-494-4133
Region IV (Ada, Boise, Elmore, Valley Counties)	800-354-2574
Region V (Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, Twin Falls Counties)	800-897-4929
Region VI (Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, Power Counties)	800-284-7857
Region VII (Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, Teton Counties)	800-919-9945

PD: First and last name of the Plan Developer.

PD Address: Agency name and mailing address where plan developer is employed. Include city, state and zip code.

PD Telephone Number: Telephone number at which Plan Developer can be reached.

Community Living Arrangement: Indicate participant's current living situation (i.e. in their own home/apartment--with or without roommates; Certified Family Home--with or without relative provider(s); Residential Assisted Living Facility (RALF).

Frequency of Plan Monitoring: Check the box that reflects the frequency of Plan Monitoring as determined by the PCP team. Monitoring must occur at least every ninety (90) days.

Participant Signature: The participant must sign in this section. If participant is unable or unwilling to sign, the Plan Developer must indicate the reason(s) why.

Do you support the plan? Participant must indicate whether they "agree" or "disagree" with the Plan by checking the appropriate box. If participant checks they "disagree" with the Plan, the Plan Developer must provide justification for submitting the plan without the participant's approval.

Planning Team Member Signatures: Signatures of individuals who are physically present at the PCP meeting.

Do you support the Plan? Each Planning Team Member must indicate whether they "agree" or "disagree" with the Plan by checking the appropriate box. If a Planning Team Member indicates they "disagree" with the Plan, the Plan Developer must clearly document that Planning Team Member's concerns in the PCP meeting notes.

Relationship to Participant: PCP Team Member must legibly print the nature of their relationship to the participant (i.e. mother, friend, uncle, etc.). If PCP Team Member is a service provider, please indicate job title and agency name in this section.

Other Planning Team Members: List first and last name of individual(s) whose input was considered when developing the plan but who were **not physically** present.

Relationship to Participant: Plan Developer must indicate the nature of the other planning team members' relationship to the participant. If a team member is a service provider, please indicate job title and agency name.

ISP SUPPORTS AND SERVICES ADDENDUM

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Developer.

Instructions:

Participant Name: Name of participant exactly as it appears on Idaho Medicaid card.

Medicaid ID#: First seven digits of the participant's Medicaid identification number as listed on Idaho Medicaid card.

Waiver Participant? Check the "yes" or "no" box to indicate whether participant is receiving waiver services.

Current ISP Start Date: Month, day and year the ISP was authorized for which an Addendum is being submitted.

Date Addendum Requested: Month, day, and year the ISP Supports and Services Addendum form is completed.

PD: First and last name of the Plan Developer.

PD Agency: Name of agency where Plan Developer is employed.

Signature of Provider Requesting Addendum: Signature of individual requesting the Addendum if it is someone other than Plan Developer.

Reason for Addendum Request: Identify which of the options listed below is the reason for submitting the Addendum. The reason must be based on participant need or want and clearly identified. More than one (1) option may be listed. Additional pages may be attached when justification is needed.

- Change of address;
- Change of telephone number;
- Addition or deletion of service (i.e. Supported Living, Community Supported Employment, DDA, etc.);
- Addition or deletion of goal(s) identified on the ISP Supports and Services form;
- Change in type of service (i.e. group vs. individual);
- Change in amount of service;
- Change in agency identified on the ISP Supports and Services form;
- Change in guardianship status (accompanied by documentation);
- Change in marital status; and
- Name change. Legal documentation must accompany.

Check this box if addendum is for change of name, guardian, address and/or telephone number *only* and add new information below: When submitting an addendum for change of name, guardian, address and/or telephone number check this box and fill in new information in the space provided.

Service Provider Column: Identify the direct provider or agency responsible for providing the *formal or informal* service and/or identify the name of the person or organization responsible for providing *natural* support(s).

Service Type: Identify the formal or informal service delivered by the service provider (i.e. Developmental Disabilities Agency, Specialized Medical Equipment, etc.).

Goals to be Addressed within the Plan Year: List at least one or more goal(s) for each support or service the participant will be working on within the plan year.

Each goal listed on the form must be given its own identifier. This identifier must include <u>both</u> a number and a letter. This two-step process for assigning a number and letter is as follows:

<u>Step 1</u>. The **numbe**r used to identify the goal should correspond to the Life Quality Domain listed below which best describes the general outcome associated with that goal.

Life Quality Domains and their corresponding numbers are as follows:

1 = Live a healthy lifestyle
2 = Obtain/maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

*For example: The goal of "Medication Management" would best be associated with the general outcome, "**Live a healthy lifestyle**", which is Life Quality Domain number "1".*

*Therefore, the number used to identify the goal "Medication Management" would be "1", which corresponds to the Life Quality Domain **"Live a healthy lifestyle"**.*

<u>Step 2</u>. The **letter** of the alphabet used to identify a goal would depend on how many goals had been developed within each Life Quality Domain. Beginning with the letter "A", each separate goal within a particular Life Quality Domain must be assigned its own identifying letter (i.e. A, B, C . . . X, Y, Z).

For example: If under Life Quality Domain number "1", you have two (2) goals, "Medication Management" and "Meal Preparation", the first goal, "Medication Management" would be assigned the letter "A" along with its Life Quality Domain number of "1". Therefore, the first goal would be identified as follows:

<u>1.A.</u> Medication Management

and the second goal, "Meal Preparation" would be assigned the letter "B" along with its Life Quality Domain number of "1" . Therefore, the second goal would be identified as follows:

<u>1.B.</u> Meal Preparation

Below are additional examples of using both a number and a letter to identify a goal when you have more than one (1) goal listed for a particular Life Quality Domain:

- *7.A. Budgeting*
- *7.B. Money Skills*
- *2.A. Obtain Housing Assistance*
- *2.B. Obtain Energy Assistance*
- *2.C. Lawn Maintenance*

NOTE: This consecutive lettering system (A, B, C . . . X, Y, Z) must continue throughout the ISP Supports and Services form and any subsequent Addendums. In other words, make sure the letter used to identify any goal(s) requested on an Addendum continue forward from the last letter used to identify a goal on the ISP and/or any prior Addendum(s) when it is within the same Life Quality Domain.

In addition, if a goal has been discontinued, do not reuse the letter attached to the discontinued goal for the remainder of the Plan year.

IMPORTANT: Even if a particular Life Quality Domain contains only one (1) goal, that goal must still be identified using <u>both</u> a number and a letter.

Proposed Start Date: Indicate the month, day and year the service and/or support is to be initially delivered.

Service Code: List the service code that corresponds with the Waiver or State Plan service. This service code can be found under the Procedure Code and Modifiers column of the most current DDA Reimbursement Rate Chart (see Appendix).

Units & Frequency of Service: This is a two-step process.

<u>Step 1.</u> To Determine **"Units"** refer to the "Medicaid Reimbursement Rate" column on the DD Reimbursement Rate Chart. In this column find the value associated with a **unit**.

Examples of units and their value are as follows:

- 1 unit=15 minutes,
- 1 unit= 1 day,
- 1 unit= 1 mile,
- 1 unit=1 time per month.

Based on the unit value determine the TOTAL number of units being requested for a particular service or support.

For example:

Transportation ⇨ If 1 unit = 1 mile and a transportation provider is requesting 50 miles of service, then 50 miles = 50 units and <u>50</u> would be the TOTAL number of units to request.

List the TOTAL number of units being requested in the "Units and Frequency of Service" column.

REMINDER: When a service provider is requesting hours of service, the number of hours requested must be multiplied by 4 to determine the total number of units.

Number of hours x 4 = Number of units

For example:

- 10 hours x 4 units per hour = 40 units

Step 2. To Determine **"Frequency"** identify how often a unit of service is being delivered. List the "Frequency" along with the "Units" in the "Units & Frequency of Service" column.

For example:

- 1 unit/***daily*** (i.e. Supported Living: Daily rate)
- 40 units/***day*** (i.e. Supported Living: Hourly)
- 80 units/***week*** (i.e. Developmental Therapy)
- 1 unit/***month*** (i.e. Service Coordination)
- 3 units/***year*** (i.e. Developmental Evaluation)
- 50 units/***week*** (mileage)

Unit Cost: Refer to the "Medicaid Reimbursement Rate" column of the DD Reimbursement Rate chart for **unit** cost. In this column find the dollar value associated with a unit. List this dollar value in the "Unit Cost" column.

For example:

- H2032: 1 unit=$4.45

REMINDER: Do not use the hourly dollar value associated with a service code, only use the dollar value associated with a UNIT.

Annual Cost: Determine the Annual cost for a "Service Type" using this formula:

UNIT COST X NUMBER OF UNITS X FREQUENCY = ANNUAL COST

Determine the "Unit Cost", "Number of Units" and "Frequency" in the following manner:

- **UNIT COST:** As identified from the "Unit Cost" column for this service.
- **NUMBER OF UNITS:** As identified from the "Units and Frequency of Service" column for this service.
- **FREQUENCY:** The multiplier used for "Frequency" is based on how often a service is being provided (i.e. daily, weekly, monthly, one time or annually). Use

the Frequency Formula below to determine the correct multiplier to use in your calculation:

Frequency Formula
Daily=365
Weekly=up to 52
Monthly= 12
One time or annually=1

For example:

UNIT COST X NUMBER OF UNITS X FREQUENCY = ANNUAL COST

$4.45 (unit cost) x 40 (number of units) x 25 (frequency) = $4,450.00 (annual cost)

Requires IPA #: For Department of Health & Welfare use only.

Previous Medicaid Annual Total: List the "Previous Medicaid Annual Total" from the existing ISP or the most recent Addendum.

Addendum Subtotal: List the subtotal cost of all services requested on the Addendum.

NOTE: When **discontinuing** a service, be sure to **subtract** the cost of the discontinued service.

New Medicaid Annual Total: Add or subtract the "Addendum Subtotal" from the "Previous Medicaid Annual Total".

Participant Signature: The participant must sign in this section. If participant is unable or unwilling to sign, the Plan Developer must indicate reason(s) why.

Date (under Participant signature line): Month, day, and year participant signed ISP Supports and Services Authorization.

Guardian Signature: The guardian's signature on the Supports and Services Addendum page indicates the guardian's request for identified services on behalf of the participant. In the event the guardian is not physically present at the PCP meeting, documentation must exist which verifies the Plan Developer forwarded a copy of the entire ISP to the guardian for review.

If a Plan Developer is unable to obtain the guardian's signature prior to submitting the ISP Addendum for authorization, the Plan Developer has the option of obtaining confirmation from the guardian that they agree with the plan by e-mail or telephone. The Plan Developer must then document in the guardian signature section the guardian's approval of the plan, the means by which the Plan Developer received approval from the guardian (e-mail or telephone) and the date the approval was received.

Although the ISP Addendum may be submitted for authorization without the guardian's signature when the above mentioned documentation is present, the Plan Developer must still require the guardian to sign, initial and forward a copy of the ISP Supports and Services Addendum to the Plan Developer via mail or fax to support the request for services. The Plan Developer must then maintain the ISP Supports and Services Addendum signed by the guardian in the participant's file for quality assurance review purposes.

Date (under Guardian signature line): Month, day, and year guardian signed ISP Supports and Services Addendum OR the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP Addendum.

Plan Developer Signature: Signature of Plan Developer.

Date (under Plan Developer signature line): Month, day, and year Plan Developer signed ISP Supports and Services Addendum.

GUIDELINES FOR DEVELOPING COST EFFECTIVE PLANS

Every effort must be made to develop services and supports that meet the participant's addressed needs and provide the most cost effective services. In addition, the method used to maintain cost effectiveness should meet the participant's personal goals.

In order to promote cost effectiveness ask these questions and consider these options:

- Are the programs based on participant choice?
- Are the services needed?
- Do the therapy programs require the amount of time being billed for?
- Are there duplicative services? If so, eliminate all duplicative services.
- Is it possible to identify or develop natural supports instead of paid supports?
- Is a personal emergency response system (PERS) or home delivered meals reasonable alternatives?

Does the participant require constant direct oversight? If not, consider these options:

- Is there a need for constant job coach presence on the job? Evaluate whether there are times the person can work without agency supervision.
- Under supported living: Can the participant benefit from some "alone time"?
- How necessary is nighttime supervision?

Is there another service or combination of services that are more cost effective and/or can better meet the needs of the participant? Consider these options:

Options**:**

- Can services be blended to result in cost savings? (i.e. group vs. individual developmental therapy, or hourly group supported living vs. 1:1)
- Consider the use of adult daycare when the participant desires socialization and/or requires supervision but chooses not to participate in developmental therapy.
- Lowest cost transportation options should be considered first.

ADDING WAIVER SERVICES
WHEN THERE IS AN EXISTING ISP

If a participant has an ISP in effect and chooses to access DD/ISSH waiver services before the next annual ISP, a Plan Developer must initiate a new Annual ISP. An Addendum cannot be used to add initial waiver services.

The date of the new Annual ISP becomes the new Annual re-determination date.

A Plan Developer must convene a Person Centered Planning (PCP) team meeting as part of developing the new Annual ISP.

Each of the following forms must be submitted to the Idaho Center for Disabilities Evaluation (ICDE) before a new Annual ISP can be processed for authorization:

- ISP "Signature" Page form
- ISP Supports and Services form
- ISP Supports and Services Authorization
- Health and Well-Being Checklist
- Personal Summary form
- Extenuating Circumstances form (if applicable)

WHEN TO INITIATE AN ADDENDUM

The circumstances under which you are required to initiate an Addendum are as follows:

- Change of address for participant.
- Change of telephone number for participant.
- Addition or deletion of a paid service (i.e. Supported Living, Community Supported Employment, DDA, etc.)
- Addition or deletion of goal(s) identified on the ISP Supports and Services form.
- Change in type of service (i.e. group vs. individual).
- Change in amount of service.
- Change in agency identified on the ISP Supports and Services form.
- Change in guardianship status.
- Change in marital status for participant.
- Name change for participant.

HOW TO INITIATE AN ADDENDUM

When a circumstance exists which requires a current service or support provider to request an addition or modification to the existing Individual Support Plan (ISP), an ISP Supports and Services Addendum form must be submitted to the ICDE for authorization.

The process for initiating an Addendum for submission to the ICDE is as follows:

Step 1. A Plan Developer and/or service or support provider may initiate an addition or modification to the existing ISP.

Step 2. The requesting provider then completes the ISP Supports and Services Addendum form according to the ISP Instruction Manual.

Step 3. The requesting provider reviews the completed ISP Supports and Services Addendum form with the participant or guardian (if applicable).

Step 4. The requesting provider (if not the Plan Developer) forwards the ISP Supports and Services Addendum to the Plan Developer.

In the event two (2) or more service and/or support providers submit separate Addendums for the same participant at the same time, the Plan Developer may generate one overall Addendum to encompass all request(s) for change if the service and/or support providers agree with this arrangement. The Plan Developer will then be responsible for obtaining all required signatures on the one overall Addendum.

Step 6. Once the Plan Developer receives an Addendum from a service and/or support provider, the Plan Developer evaluates whether it is necessary to convene a Person Centered Planning (PCP) meeting to discuss the proposed request and verify the participant's or guardian's (if applicable) agreement with the request as stated in the ISP Supports and Services Addendum.

Step 7. Once it has been verified by the Plan Developer that the participant is in agreement with the Addendum request, the Plan Developer determines the financial impact of the request relative to the participant's annual budget.

If the Addendum request put the plan over budget, the Plan Developer collaborates with the PCP team to discuss alternatives to the plan going over budget. If the PCP team determines that alternatives cannot be identified which will allow the plan to remain within the participant's budget, the Plan Developer, together with the PCP team, must complete an Extenuating Circumstances form.

Step 8. The Plan Developer will then submit the ISP Supports and Services Addendum form along with the Extenuating Circumstances form (if applicable) to the ICDE for authorization.

GUIDELINES FOR VACATIONS IN CERTIFIED FAMILY HOMES

Vacation is defined as: when the waiver participant is away from their normal living arrangement and their normal routine; weekends and holidays are not considered vacations, as they are typically leisure in nature.

When a participant chooses *not to* substitute the CFH provider on vacation, the CFH provider must ensure the replacement provider has a copy of the Individual Service Plan (ISP) and is trained in the needs of the participant.

When a participant chooses *to* accompany the Certified Family Home (CFH) provider on vacation and the provider requests reimbursement for services provided during the vacation, the following guidelines apply:

- During the Person Centered Planning meeting, participants and their team must discuss participant interest and choice in accompanying the CFH provider on vacation, and

- Participants must again be offered the choice to accompany CFH providers on vacation immediately prior to vacation to ensure continued agreement, and

- The duration of the vacation cannot interfere with participant's progress in activities to become more independent nor can it jeopardize participant health, welfare, or current employment status; and

- Documentation requirements continue as usual and must include the duration of the vacation and any modification of residential habilitation services required for those services in a different location.

Note: Medicaid Eligibility Rules and waiver rules state that participants will lose Medicaid eligibility if they are out of state longer than one (1) month (IDAPA 16.03.05.101).

CHANGE IN PLAN DEVELOPER WITHIN THE PLAN YEAR

If a participant chooses to change their Plan Developer within the current plan year and the “new” Plan Developer is employed by a different service coordination agency, the request for Plan Development hours must be submitted on an ISP Supports and Services Addendum form to the Idaho Center for Disabilities Evaluation (ICDE) by the “new” Plan Developer.

The following questions should be taken into consideration by the “new” Plan Developer when generating the addendum:

- Does the “new” Plan Developer need to request hours for plan development for the rest of the plan year?
- Does the “new” Plan Developer need to develop an Addendum to change participant goal(s)?
- Does the “new” Plan Developer need to develop an Addendum to add or delete services?
- Do hours need to be requested only for a change in Plan Developer?
- Do hours need to be requested only for future Addendum(s) for the remainder of the plan year?

If hours are requested, the number of hours requested should reflect a reasonable amount of time needed to complete the anticipated Plan Development activities.

TRANSITIONING

Include a process to assist the participant to transition to a more independent level under the following circumstances:

- The participant has consistently shown progress during the current or previous plan year to the point where he/she will no longer need the amount, frequency or intensity of service they are currently receiving; or
- The participant is expected to no longer need or meet the criteria for Waiver services at the point of their next annual re-determination.

Assisting a participant to transition to a less intensive level can be included in a goal on the annual ISP or can be added as an Addendum at any time that it is needed.

Transition goals will be identified in the personal summary Supports and Services on the ISP and Program Implementation Plans.

A Transition Goal will be implemented as part of an implementation plan and will include the following:

- A specific goal to be addressed within a time frame ;
- The frequency that it will run;
- The agency or provider responsible for the program.
- A progressive and planned fading of the intensity, frequency and/or duration of supervision by a paid support or service such as:
    - A lessening of the amount of hours of required supervision; and
    - A resulting increase in time spent alone or without paid supports.
- A safety plan in the event that the participant requires immediate help at a time when paid support is not available.

HW0760 October 2005 Revised

Idaho Department of Health and Welfare
ISP SUPPPORTS AND SERVICES AUTHORIZATION

Region _____ Field Office _____
ISP Start Date _____
ISP End Date _____
DHW or DHW designee signature
_____

Date ISP Completed: Initial Plan ☐ Annual ☐ Waiver Participant? Yes ☐ No ☐
Participant Name: Medicaid ID#:
Plan Developer: Plan Developer Agency and address:

Waiver Participant Initials: _____ I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an ICF/MR. I understand that I may, at any time, choose facility admission.

Service Provider	**Service Type**	**Proposed Start Date and End Date**	**Service Code**	**Units & Frequency of Service** (#/day/week/month)	**Unit Cost** ($/hr/day)	**Annual Cost**	**Requires PA Check yes or no This column for Department use only**
WAIVER							
							☐ yes ☐ no
							☐ yes ☐ no
							☐ yes ☐ no
STATE PLAN							
							☐ yes ☐ no
							☐ yes ☐ no
							☐ yes ☐ no
							☐ yes ☐ no
						Medicaid Annual Total _____	

Authorization is requested for the services listed above by the following people:

PARTICIPANT SIGNATURE

GUARDIAN SIGNATURE (if applicable)

PLAN DEVELOPER SIGNATURE

Idaho Department of Health and Welfare

ISP SUPPPORTS AND SERVICES AUTHORIZATION

Region _____ Field Office _____
ISP Start Date _____
ISP End Date _____
DHW or DHW Designee Signature
_____

Date ISP Completed: Initial Plan ☐ Annual ☐ Waiver Participant? Yes ☐ No ☐
Participant Name: Medicaid ID#:
Plan Developer: Plan Developer Agency and address:

Waiver Participant Initials: _____ I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an ICF/MR. I understand that I may, at any time, choose facility admission.

Service Provider	Service Type	Proposed Start Date and End Date	Service Code	Units & Frequency of Service (#/day/week/month)	Unit Cost ($/hr/day)	Annual Cost	Requires IPA #
WAIVER							
Reshab Agency	Individual Reshab-Supported Living	01/01/05-12/31/05	H2015-U8	384 units/week	$1.87	$37,340.16	☐ yes ☐ no
STATE PLAN							
Service Coordination Agency	Plan Development	12/01/04-11/30/05	G9007	48 units/year	$10.00	$480.00	☐ yes ☐ no
Service Coordination Agency	Service Coordination	01/01/05-12/31/05	G9002	1 unit/month	$108.33	$1,299.96	☐ yes ☐ no
Developmental Disabilities Agency	Developmental Therapy-Community Individual	01/01/05-12/31/05	H2032	40 units/week	$4.45	$9,256.00	☐ yes ☐ no
						$48,376.12 Medicaid Annual Total	

Authorization is requested for the services listed above by the following people:

PARTICIPANT SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE (if applicable) _____ DATE _____

PLAN DEVELOPER SIGNATURE _____ DATE _____

REVISED 09-06

Idaho Department of Health and Welfare
PERSONAL SUMMARY

Participant Name: Gender:

Medicaid Number: Date of Birth:

Current Status: Using a strengths-based approach, describe the individual in each of the following areas that apply: Health, Living Situation, Family Relations, Behavioral Issues, Employment, Legal Status, Communication, Mobility, Financial Status, and Religious Preference.

Assessed Needs: Resources to gather this information-The SIB-R Report, Medical Care Evaluation Form, Developmental Disability Medical, Social and Developmental Assessment Summary or any other evaluations as well as any recommendations provided by PCP Team. Review the individual's current status and identify their needs in each area that applies:
Health:
Living Situation:
Family Relations:
Behavioral Issues:
Employment:
Legal Status:
Communication:
Mobility:
Financial Status:
Religious Preference:
Other:

Long-term goals: The list of long-term goals should be defined by the participant and relate to the assessed need. Long-term goals are broader in nature and are used to guide the development of goals to be addressed within the plan year as identified on the ISP Supports and Services page**.**

Long-term goals and desires must enhance and/or maintain :

- Independence;
- Quality of life; and,
- Lead to greater choice and self-direction for the participant.

List below those assessed needs that will have associated goals for this plan year.

Correlate identified assessed needs to a long term goals in each identified area:

ASSESSED NEED	LONG TERM GOAL
1.	

Each identified need must have a long term goal associated with it. Each long term goal must have a one year goal identified on the ISP with a correlating support or service. The support or service can be formal or informal, paid or non-paid.

List those assessed needs that will not be addressed this plan year and the rationale supporting this decision.

DEFERRED NEED	REASON FOR NOT ADDRESSING THE NEED
1.	

Idaho Department of Health and Welfare
PERSONAL SUMMARY: EXAMPLE

Participant Name: Gender:

Medicaid Number: Date of Birth:

Current Status: Using a strengths-based approach, describe the individual in each of the following areas that apply: Health, Living Situation, Family Relations, Behavioral Issues, Employment, Legal Status, Communication, Mobility, Financial Status, and Religious Preference.

Gary is a 53-year-old man who lives in a supported living apartment setting with two other roommates. Gary enjoys living and socializing with his roommates. He thoroughly enjoys learning about cars and assembling miniature model cars, especially muscle cars. More of his hobbies center on going to the library to get books about cars or going into different hobby stores to obtain new model cars to assemble in his spare time. Gary spends a lot of time with his two sisters as well, during the weekends and most holidays. Gary is diagnosed with mild mental retardation and severe depression. He has issues with managing his weight and eating healthily. He also can be aggressive at times and has destroyed property and threatened to hurt others. (Gary has hit the wall with his fist and made holes in doors.) Most of these outbursts occur due to food related issues. Gary relates that he would like to eat more things like ice cream and chips, but he knows it is bad for his health. He will often make dinner for his roommates or share his food and this would be taken advantage of if staff did not intervene. Gary has had several concerns with managing his money in the past or giving it out to others too freely. He shares that he knows he must have support with this to be able to be more independent. Gary is looking towards obtaining employment in a sheltered workshop and looks forward to earning this extra money. Gary also needs help with remembering to take his medication regularly and on time. He knows that without it, he can become very tired and sleep all day. Gary is his own guardian. He has no issues or concerns regarding mobility or religious preference.

Assessed Needs: Resources to gather this information-The SIB-R Report, Medical Care Evaluation Form, Developmental Disability Medical, Social and Developmental Assessment Summary or any other evaluations as well as any recommendations provided by PCP Team. Review the individual's current status and identify their needs in each area that applies:
Health: Gary needs to be able to make healthy food choices in order to maintain his appropriate weight.
Living Situation: N/A
Family Relations: N/A
Behavioral Issues: Gary would like to continue to visit with his counselor once a week and work on not hitting himself or others when he is frustrated.
Employment: Gary would like to research getting a job in a workshop setting.
Legal Status: N/A
Communication: Gary would like to learn how to express his likes and dislikes without becoming frustrated or angry. Gary would like to be able to learn to have appropriate interactions with his roommates, friends, and explore dating.
Mobility: N/A
Financial Status: Gary needs a representative payee to assist with his financial situation.
Religious Preference: n/a
Other: Gary has had problems during the past year with aggression toward himself and others.

Long-term goals: The list of long-term goals should be defined by the participant and relate to the assessed need. Long-term goals are broader in nature and are used to guide the development of goals to be addressed within the plan year as identified on the ISP Supports and Services page**.**

1. **Make healthy meals and food choices to maintain weight loss. ("I have to stay healthy as I get older.")**
2. **Maintain a payee to assist with financial issues and savings for things I want to buy or do.**
3. **Get a job to have more money to spend on hobbies, such as model car collection or movies.**
4. **Make more friends outside of my roommates and start dating.**
5. **Learn how to cope better with anger and frustration.**

Long-term goals and desires must enhance and/or maintain:

- Independence;
- Quality of life; and,
- Lead to greater choice and self-direction for the participant.

Correlate identified assessed needs to a long term goals in each identified area:

ASSESSED NEED	LONG TERM GOAL
Managing weight.	Make healthy meals and food choices to maintain weight loss.
Help with financial issues.	Maintain payee to save money and buy and do things I want.
Would like to get a job.	Get a job to have more money to spend on hobbies.
Learn how to make and keep friend.	Make more friends and start dating.
Stop hurting self or threatening to hurt others.	Seek a counselor or another professional to get help.

Each long term goal must have a one year goal identified on the ISP with a correlating support or service. The support or service can be formal or informal, paid or non-paid.

List those assessed needs that will not be addressed this plan year and the rationale supporting this decision.

DEFERRED NEED	REASON FOR NOT ADDRESSING THE NEED
1. Communication	Working through behavioral needs before working on communication needs.

Name:
Date of PCP Meeting:

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)

Name: John Someone

Date of PCP Meeting: 10/06/05

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)
Plan Development **Informal Services**	9A. Schedule, notify and facilitate Person Centered Planning Team. 9B. Obtain documents and information to develop/write ISP. 9C. Attend budget meeting. 9D. Generate addendums to ISP.	12 hrs/year (plan development can not exceed 12 hrs a year)	Jayne Smith, XYZ Service Coordination Agency	09/15/05
Service Coordination **Informal Services**	9D. Telephone contact. 9E. Face to face contact. 9F. Monitor progress in services, attend meetings as invited, advocate on John's behalf, assist to resolve any difficulties which may arise. 9G. Assist John w/ finding and coordinating Medicaid & non-Medicaid services in the community. Assure non-duplication of services. 9H. Protocol in case of emergency is as follows: ….. 9I. Pursue guardianship with brother.	1 time/month or as needed 1 time/every other month or as needed 1 time/month or as needed As needed As needed. Until completed.	Jayne Smith, XYZ Service Coordination Agency	

Name: John Someone
Date of PCP Meeting: 10/06/05

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)
Residential Habilitation (CFH) **Formal Services**	3A. Encourage John's independence in all activities of personal hygiene 7A. Assist John to purchase clothing appropriate to the weather.	Daily As needed	Sally Jones	
Residential Habilitation (CFH) **Informal Services**	1A. Assist John with medications. 9A. Alternate Care as needed. Service Coordinator will be notified when John is in Alternate Care and who the provider is. 4A. Encourage John's communication with family.	As needed As needed Daily or as needed	Sally Jones	

Name: John Someone
Date of PCP Meeting: 10/06/05

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)
Residential Habilitation (Supported Living) **individual** **Formal Services**	2C. Increase housekeeping skills. 3B. Increase personal hygiene skills.	21 hrs week for all goals	A Reshab Agency	
Residential Habilitation (Supported Living) **Informal Services**	3C. Alone time. 1B. Accompany John to Doctor appointments. 8B. Provide opportunity for John to go on vacations of his choosing up to thirty days per year.	1 hr/week As scheduled As requested	A Reshab Agency	
DDA Services **Formal Services**	3D. Task completion. 4B. Communication with strangers in the community. 7B. Number recognition.	Center Group – Community Group- Center Individual- 15 hrs/week for all goals (in this example these goals are being trained in DDA service mix)	A Certain DDA	

Name: John Someone
Date of PCP Meeting: 10/06/05

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)
Medical Transportation **Informal Service**	3E. Transportation to and from DDA / home	36 miles roundtrip 3 times/week	Transportation Company	
Non-medical Transportation **Informal Services**	3F. Transportation to and from Adult Day Care Center / home. 3G. Transportation from Adult Day Care Center to job.	36 miles roundtrip 2 times/week 3 miles one way 2 times/week	Another Transportation Company Another Transportation Company	
Adult Day Care **Informal Services**	3H. Activity choices at the facility. 4C. Socialization with peers. 6A. Choose community activities to participate in.	15 hrs/week	Adult Day Care Provider	
Waiver Community Supported Employment (CSE) **Formal Service**	5A. Maintain a job 5B. Increase time management skills. 5C. Increase appropriate interaction with co-workers.	9 hrs/week	CSE Provider	

Name: John Someone
Date of PCP Meeting: 10/06/05

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)
Natural Supports	4D. Attend Special Olympics. 6B. Attend church with family member. 7C. Mother will assist with money management as representative payee for SSI payments.	1 time/ month or as desired 1 time/week or as desired 1 time/week and as needed	Family Family Ann Jones (mother)	
Psychosocial Rehabilitative Services **Formal Services**	7D. Coping skills relating to Financial Stressors. 4E. Manage symptoms of anxiety while in the community. 3I Teach strategies to make decisions.	Individual-6 hrs/wk For all goals	PSR Agency	
Mental Health Clinic **Informal Services**	1C. Medication Management 1D. Psychotherapy -Symptom management	1 time/month and as needed 1 hr/week	H & W Mental Health Clinic	

Idaho Department of Health and Welfare

ISP SUPPORTS AND SERVICES: TRANSITION PROGRAM EXAMPLE

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle
2 = Obtain/Maintain a personal residence
3 = Live as independently as I am able
4 = Engage in socially appropriate interactions
5 = Work at a job I like
6 = Participate actively in my community
7 = Manage my personal finances
8 = Manage my personal time
9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	**Goals to be Addressed within Plan Year**	**Frequency**	**Agency or Provider** (Formal Services, Informal Services, Natural Supports)	**Start Date** (When different than Proposed ISP Start Date)
Residential Habilitat6ion (Supported Living) individual **Transition Program**	2. a. Identify and sign up for all low-income housing options available in Canyon county. b. Maintain checking account successfully and buy all personal items from checking account. 3. a. Increase amount of time that I can be without formal supervision in my apartment to include all hours of sleep. Implementation plan will identify the process to fade staff over the next year.	2. a. 2 hours per week 2. b. one hour per week 3. 2 times a day.	A Reshab. Agency	11/01/06

Idaho Department of Health and Welfare
INDIVIDUAL SUPPORT PLAN

For individuals living in Certified Family Homes, this ISP meets the requirements of a Negotiated Service Agreement in Certified Family Home rules, IDAPA 16.03.19, when accompanied by a current Health and Well Being Form and Residential Habilitation Implementation Plan(s).

Name: Medicaid #:
Address:
Telephone #: Date of Birth:
Guardian (if applicable): Guardian Address:
Guardian Phone #: Emergency Contact (if applicable):
Date of Person Centered Planning Meeting (PCP): Initial Plan ☐ Annual ☐ Healthy Connections? Yes ☐ No ☐
Plan Developer: Plan Developer telephone#:
Plan Developer Agency and Address:
Community Living Arrangement:
Frequency of Plan Monitoring: ☐ 30 days ☐ 60 days ☐ 90 days

Person Centered Planning Team Members				
Participant Signature:		Do you support the plan?	Agree ☐ Disagree ☐	
Planning Team Member Signatures	Do you support the plan?	Relationship to Participant	Other Planning Team Members	Relationship to Participant
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			

Region _____Field Office _____
Addendum Start Date_____
Authorization Start Date_____
ISP end Date _____
DHW or DHW designee signature
_____

Idaho Department of Health and Welfare
ISP SUPPORTS AND SERVICES ADDENDUM

Participant Name: Medicaid ID#:

Waiver Participant Yes ☐ No ☐ Current ISP Start Date:
Date Addendum Requested: Plan Developer (PD):
PD Agency and address: Signature of Provider Requesting Addendum: _____
Reason for Addendum Request:

☐ √ **Check this box if addendum is for change of name, guardian, address and/or telephone number *only* and add new information below.**

New Participant Name: New Telephone #:
New Guardian Name: New Mailing Address:
New Physical Address: New Mailing Address:

This Column For Department Use Only

Service Provider	Service Type	Goal to Be Addressed Within Plan Year	Proposed Start and End Date	Service Code	Units & Frequency of Service (#/day/week/month)	Unit Cost ($/hr/day)	Annual Cost (To be completed by PD)	If yes, enter IPA # This Column For Department Use Only
Previous Annual Medicaid Cost _____								
								☐ yes ☐ no
								☐ yes ☐ no
								☐ yes ☐ no
								☐ yes ☐ no
Addendum Sub-Total _____								
New Medicaid Annual Total _____								

Authorization is requested for the services listed above by the following people:

PARTICIPANT SIGNATURE GUARDIAN SIGNATURE (if applicable) PLAN DEVELOPER SIGNATURE

PROVIDER STATUS REVIEW INSTRUCTIONS

The Plan Monitor will request a Provider Status Review from the following service providers:

- Developmental Disabilities Agency (DDA) providing individual or group developmental therapy
- DDA providing Occupational Therapy, Physical Therapy and Speech Therapy
- Residential Habilitation—Supported Living
- Community Supported Employment (CSE)

Each of these service providers must submit a Provider Status Review to the Plan Monitor two (2) times per year. The first Provider Status Review is due six (6) months after the plan start date. Individual providers should be prepared to discuss the six month reviews and any additional changes at the Person Centered Planning Meeting. The second Provider Status Review is due at the end of the plan year. The annual Status Review will be submitted to the Plan Monitor for filing in the participant file and a copy will be sent to the IAP for their files.

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Monitor.

Instructions:

Participant: Name of participant exactly as written on Idaho Medicaid card.

Medicaid Number: First seven digits of the Medicaid identification number listed on the participant's Idaho Medicaid card.

Plan Start Date: Month, day and year the ISP Supports and Services Authorization Page was approved by the Department or its designee.

Provider Agency: Name of direct provider or agency responsible for providing the formal service.

Type of Service: Identify which service type is being delivered by the Provider Agency (i.e. DDA, OT, PT, Speech, Residential-Habilitation Supported Living, CSE).

Semi-Annual Review (Mo/Yr): Indicate the month and year the Provider Status Review was completed if this is a six month Provider Status Review. Leave this section blank if this is an Annual review.

Annual Review (Mo/Yr): Indicate the month and year the Provider Status Review was completed if this is an annual Provider Status Review. Leave this section blank if this is a Semi-Annual Review.

Professional Completing Review: Name and title of individual completing Provider Status Review.

Domain/Goal: Locate the number and letter associated with the goal you are reporting on from the ISP Supports and Services page and enter it into the domain/goal box.

Behavioral Objective: List the behavioral objective associated with the goal referenced by a number and letter in the domain/goal box. Use a separate row in the table for each behavioral objective associated with that particular goal.

Baseline Statement: Definition: An assessment of performance under natural conditions before instruction occurs. The baseline describes the level of a skill or behavior before we try to change it. The baseline must be identified both on the Program Implementation Plan and on the Provider Status Review. Write in the baseline statement for each objective. When a new objective is started, a new baseline should be identified prior to intervention techniques on the Implementation Plan.

NOTE: The methodology used to determine a baseline statement can vary. Depending on the preference of the service provider, the baseline statement may be identified by percentages or ratios, (i.e. 50% of the time, 3 out of 4 times).

Baseline Date of Assessment: Write in the original date that the Baseline was taken, measured, or assessed, prior to any instruction. If you do not know what the date was or if you do not have an original or accurate baseline, you must do a **Probe Assessment** to determine the current level of functioning and start at that point. (**See: Probe Specific Skill Assessment.)**

Probe Specific Skill Assessment: The level of a skill or behavior after training is started, but with no assistance, prompts, cues, or positive reinforcement that were part of an instruction.

Blank columns for summary of monthly data collection: Beginning with the first month after the Plan is authorized; enter monthly data compiled from the referenced objective in the first blank column. Continue this reporting process for the next five (5) months by entering the results of monthly data collection into each of the blank columns that follow. Be sure to indicate at the top of each column the month and year for which the data is being reported.

NOTE: The methodology used to report data collection can vary. Depending on the preference of the service provider, data collection may be reported by percentages or ratios, (i.e. 50% of the time, 3 out of 4 times).

6 month review: Using a number from the “Key for Reporting Progress Towards Outcomes”, report the overall progress achieved by the participant for the first six months of service delivery by entering this number into the six month box along with the monthly data reported for that month. The number used from the “Key” must be supported by the results entered for the prior six months’ of data collection. The Provider Status Review is based on full month’s data. The 6 month PSR will be submitted 15 working days from the due date of the 6 months review.

1 year review: Continue to report on data collected for the next six (6) months by entering the results of monthly data collection into each of the remaining six (6) columns. Using a number from the "Key for Reporting Progress Towards Outcomes", report the overall progress achieved by the participant for the plan year by entering this number into the last column along with the monthly data reported for that month. The number used from the "Key" must be supported by the results entered for the entire years' data collection. The annual Status review is due 30 working days from the end date of the Plan.

Comment on each objective: The provider must indicate the reason(s) or circumstance(s) that contributed to results which reflect no progress, a decline in progress or discontinuation of an objective. Comments should be included for any month during the plan year in which no progress, a decline in progress, or discontinuation of an objective has occurred.

PROVIDER STATUS REVIEW

PARTICIPANT:		**MEDICAID NUMBER:**		**PLAN START DATE:**	
PROVIDER AGENCY:		**TYPE OF SERVICE:**			
SEMI-ANNUAL REVIEW (MO/YR):		**ANNUAL REVIEW (MO/YR):**			
PROFESSIONAL COMPLETING REVIEW:					

Key for Reporting Progress Towards Outcomes
Behavioral Objectives Reporting Key

1 = Achieved (100% of established criteria)

2 = Substantial Progress (50% or better of the established criteria)

3 = Some Progress (Less then 50% of the established criteria)

4 = No progress (No change from previous report)

5 = Decline in Progress (Below established baseline)

6 = Maintenance

* = Change in Plan

FORMAL SERVICES (PROGRAM OBJECTIVES/DATA COLLECTION)			6 mos									12 mos		
DOMAIN/ GOAL	**BEHAVIORAL OBJECTIVE**	**Baseline Statement Date of assessmnt** _____												
Comment:														
Comment:														
Comment:														
Comment:														
Comment:														

Revised: October 2005

PROVIDER STATUS REVIEW (Example)

PARTICIPANT:	Joe Bob Smith	**MEDICAID NUMBER:**	0123456	**PLAN START DATE:**	9/1/05
PROVIDER AGENCY:	ACME Developmental	**TYPE OF SERVICE:**	**DDA**		
SEMI-ANNUAL REVIEW (MO/YR):	3/1/06	**ANNUAL REVIEW (MO/YR):**			
PROFESSIONAL COMPLETING REVIEW:	**Jimmy Joe, DS**				

Key for Reporting Progress Towards Outcomes
Behavioral Objectives Reporting Key

1 = Achieved (100% of established criteria)

2 = Substantial Progress (50% or better of the established criteria)

3 = Some Progress (Less then 50% of the established criteria)

4 = No progress (No change from previous report)

5 = Decline in Progress (Below established baseline)

6 = Maintenance

* = Change in Plan

FORMAL SERVICES (PROGRAM OBJECTIVES/DATA COLLECTION) 6 mos 12 mos

DOMAIN/ GOAL	BEHAVIORAL OBJECTIVE	Baseline Statement 08/01/05	9/05	10/05	11/05	12/05	1/06	2/06						
3. d	Joe picks up after himself at lunch 50% of ten trials.	Joe picks up after himself at lunch 10% of ten trials	10%	9%	10%	18%	25%	40% **(3)**						
Comment: During the first six months Joe has completed six of the ten steps to clean up after himself at lunch. He is learning to focus better and ignore distractions.														
4. b	Joe will communicate appropriately with strangers 10% of ten trials	Joe talks to strangers appropriatel y 5% of ten trials	5%	1%	2%	3%	4%	6% **(5)**						
Comment: Joe showed a decline from the base line because he was ill and did not get into the community to come in contact with strangers in the community.														
7. b	Joe recognizes numbers 1-12 on an analog clock 50% of four trials	Joe recognizes #s (1-12) on an analog clock 25% of four trials	25%	27%	25%	26%	28%	25% **(3)**						
Comment: Joe improved slightly from his base line. Additional training to staff will occur over the next two months to ensure the program is being run correctly.														
Comment:														

PLAN MONITOR STATUS SUMMARY

Plan Monitor Status Summary Guidelines

1. The Plan Monitor must complete a Plan Monitor Status Summary two (2) times per year. This summary is based on the Provider Status Reviews that are submitted to the Plan Monitor six (6) months after the plan start date and at the end of the plan year.

2. The Plan Monitor should contact the participant after reviewing the 6 month Provider Status Review to assure they are satisfied with their services.

3. The Plan Monitor will use the provider information from the Provider Status Reviews to evaluate plans and initiate action to resolve any concerns. The summary is based on evaluating the goals and objectives to be accomplished within the plan year.

4. Comments shall include concerns, need for follow-up, or need to reconvene the person-centered planning team. If there is no need for a comment, use a phrase similar to “no comment”.

5. The Plan Monitor will bring the six month provider status reviews, the six months Plan Monitor Summary, as well as any additional information to the Person Centered Planning Meeting to develop the annual plan. All of this information is submitted with plan for authorization. The annual Provider Status Review and Plan Monitor Status Summary will be submitted to the ICDE at the end of the plan year.

Plan Monitor Status Summary Sections Defined

- The form is divided into three sections:
    - Formal services: Services are paid and have behavioral objectives (i.e. supported living, DDA or CSE).
    - Informal services: Services are paid but do not have behavioral objectives (i.e. transportation, DME, etc.).
    - Natural supports: Activities that are not paid and do not have behavioral objectives (i.e. attend church with family member, play cards with neighbor, attend Special Olympics, participate in recreational activities, etc.).

REMINDER: All forms must be typed AND all fields within the form must be completed. Forms that do not comply will be returned to the Plan Monitor.

Plan Monitor Status Summary Instructions

Participant: Name of participant exactly as written on Idaho Medicaid card.

Medicaid Number: First seven digits of the Medicaid identification number listed on the participant's Idaho Medicaid card.

Plan Start Date: Month, day and year the ISP Supports and Services Authorization Page was approved by the Department or its designee.

Semi-Annual Review (Mo/Yr): Indicate the month and year the Provider Status Review was completed if this is a six month Provider Status Review. Leave this section blank if this is an Annual review.

Annual Review (Mo/Yr): Indicate the month and year the Provider Status Review was completed if this is an annual Provider Status Review. Leave this section blank if this is a Semi-Annual Review.

Formal Services: The plan monitor will write a summary of the progress reported on the Provider Status Reviews received at six (6) months and at the end of the plan year. The summary should also include concerns, need for follow-up or need to reconvene the person-centered planning team. For example, if progress is being made at the six month review, a comment might be "Continue until annual review date". If there has been no progress on an objective, a comment might be "Participant has not yet begun to work on this particular objective, but will begin in the next six month period." If the participant has worked on the objective and has not yet been able to make progress the comment might be, "Discontinue objective as participant has been unable to address this objective or refer to Person Centered Planning Team for reevaluation of the objective." If there is no need for a comment, use a phrase similar to "no comment".

Informal Services: The plan monitor will write a summary reporting on the goals identified for each informal service on the ISP Supports and Services page in the column "Goals to be Addressed within Plan Year". Comments should include status of the goal (i.e. continuing, discontinued, on hold, etc.) progress made toward achieving the goal, concerns, need for follow-up and/or need to reconvene the person-centered planning team.

Natural Supports: The plan monitor will write a summary reporting on the goals identified for each natural support on the ISP Supports and Services page in the column "Goals to be Addressed within Plan Year". Comments should include status of the goal (i.e. continuing, discontinued, on hold, etc.), progress made toward achieving the goal, concerns, need for follow-up and/or need to reconvene the person-centered planning team.

Plan Monitor Name: First and last name of Plan Monitor.

Plan Monitor Signature: Signature of Plan Monitor.

Date: Month, day, and year Plan Monitor signed the Plan Monitor Status Summary.

PLAN MONITOR STATUS SUMMARY

Instructions: The Plan Monitor will complete a Plan Monitor Status Summary two (2) times per year. This summary is based on the Provider Status Reviews that are submitted to the Plan Monitor six (6) months after the plan start date and at the end of the plan year. The Plan Monitor should contact the participant at the (6) month review to assure they are satisfied with their services. The Plan Monitor will use the provider information as a tool to evaluate plans and initiate action to resolve any concerns. **The Plan Monitor must report on informal services and natural supports.**

Participant Name:	**Medicaid Number:**	**Plan Start Date:**
Semi- annual review date:	**Annual review date:**	

Use the semi-annual date line for the 6 month review and the Annual date line for the annual review. Do not put dates on both lines.

Formal Services:

Informal Services:

Natural Supports:

_____ _____ _____

Plan Monitor Name Plan Monitor Signature Date

Revised: October 2005

Plan Development Authorization Cover Sheet

Date	Assessor	Participant
PA Start Date **(Date provided by the PD)**	**PA End Date**	**MID #**
Plan Developer and Agency Name: (*please print)*		

Plan Development Services Have Been Authorized:

(for regional office use only)

Service	Frequency	Provider Number	Prior Authorization #
G9007 Plan Development	**12 hours / year**		

5/11/05

Health and Well Being Checklist

Name Date

1. Is adequate assistance available for safe evacuation during an emergency in the home or community?
☐Yes ☐ No Describe how this will be addressed.

2. Describe how the participant takes any medication, including medication administration and assistance. See the reverse side of this form for definitions of these terms.

3. Does the participant have any unstable health or medical conditions? ☐Yes ☐ No If yes, how will these conditions be monitored?

Please list current medical and psychiatric conditions as evidenced by medical records:

a.
b.
c.
d.

Please list medications that treat the above conditions:

a.
b.
c.
d.

Please list all known allergies:

a.
b.
c.
d.

(If more space is necessary, please continue on a blank sheet.)

4. Have there been any recurrences of situations that would put the participant or others in danger?
☐ Yes☐ No If yes, describe plans to ensure safety

5. Has there been a weight loss or gain that indicates nutritional or medical needs are not being met?
☐ Yes☐ No If yes, how is this being addressed?

6. Are nursing or nursing oversight services required? ☐ Yes☐ No If yes, describe the nursing or nursing oversight services.
Are nursing services being delegated? ☐ Yes ☐ No If yes, what training was provided?

7. Are there structural, physical, emotional, or environmental barriers that would present concerns related to the well being of the participant? ☐ Yes ☐ No Explain any barriers.

8. Describe the involvement and support of the SC, PCP Team, primary physician (if applicable) and the family/support system in resolving the well being issues.

9. What alternatives, strategies, and resources have already been tried to alleviate participant well being issues?

10. What changes could be made to resolve any unresolved participant well being issues? Explain any changes.

Attach additional comments if more space is needed.

Health and Well Being = assurance that protection from injury, illness or fatality has been considered in the consumer's living arrangement, including all services and supports.

Purpose of the Health and Well Being Form:
The Health and Well Being Form is used to assist Plan Developers to determine whether health and safety needs can reasonably be met for adults receiving developmental disabilities services. While normal exposures to risks occur in any setting, efforts must be taken to reduce threats to a person's health and well being while receiving waiver services./

Nursing Guidelines are contained in a separate document and assist the Plan Developer in evaluating a person's need for nursing services. The Plan Developer uses a variety of resources in determining how best to coordinate services and supports to assure the health and well being of adults with developmental disabilities.

The following definitions of terms are taken from Title 23, Chapter 1 of Idaho Administrative Rules and Procedures Act (IDAPA), Rules of the Board of Nursing:

A02. Administration of Medications. The process whereby a prescribed medication is given to a patient by one of several routes - oral, inhalation, topical, or parenteral. The nurse verifies the properly prescribed drug order; removes the medication from stock supply or a previously dispensed, properly labeled container (including a unit dose container); assesses the patient's status and disease process; assures that the drug is given as prescribed to the patient for whom it is prescribed and that there are no known contraindications to the use of the drug or the dosage that is being prescribed; prepares the medication in accordance with accepted principles and procedures as taught in nursing curricula; records the time and dose given; and assesses the patient following administration for expected effects and possible untoward side effects. Administration of medication is a complex nursing responsibility, which requires knowledge of anatomy, physiology, pathophysiology and pharmacology. Licensed nurses may administer medications and treatments as prescribed by health care providers authorized to prescribe medications.

A05. Assistance with Medication. The designated care provider in a non-institutional care setting aids the patient who cannot independently self-administer medications, provided that:

a. The patient's health condition is stabilized.

b. The patient does not require nursing assessment of health status before receiving the medication nor nursing assessment of the therapeutic or side effects after the medication is taken.

c. The medication is a maintenance level drug given at routine times by a non-injectable route.

d. The medication is in the original pharmacy-dispensed container with proper label and directions or the medication has been removed from the original container and placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container.

e. Written and oral instructions have been given to the designated care provider by a licensed physician, pharmacist or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency.

f. Any medication dosages not taken and the reasons thereof are recorded and reported to appropriate supervisory persons.

g. Assistance with medication does not include mixing or compounding a medication. Assistance with medication may include: breaking a scored tablet; and aiding the patient who requires non-routine dosages of oral medications for seizure activity or for the symptomatic relief of pain, only after proper instruction from a licensed physician, pharmacist or nurse and if the patient is assessed at least monthly by a licensed physician or nurse. Inventories of any narcotic medications are to be maintained.

h. Injectable medication that cannot be self-administered shall be administered only by a licensed nurse or by persons exempted from licensure.

MID #:

Plan of Service Date:

Extenuating Circumstances

This is a request for services beyond the identified negotiated participant budget. The Person Centered Planning Team has evaluated all the requested services and has determined there are no natural supports or less costly services available to meet the participant's current assessed needs. The need for additional services is based on one or more of the medical necessity criteria as follows. Supported living acuity based level of supports are identified at IDAPA 16.03.10.04.

Medical Necessity Criteria
A service is medically necessary if:

a. It is reasonably calculated to prevent, diagnose or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunctions.

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.

c. Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

Plan Developers complete this form.

1. Identify each of the applicable primary categories and use the prompts to help specify the type of information to include in the request.

2. Documentation shall include enough information to justify the need for additional services. Additional information may be attached to this form if necessary.

3. Completed form and documentation is submitted to the IAP for review. The Documentation should be specific to Time, Frequency, and Intensity of the need for additional funding.

Extenuating Circumstances

Primary Categories	*Narrative*
1. Behavioral Health or Psychiatric: Prompts: ☐ The behavior is of such intensity it poses danger ☐ There is risk of victimization to others ☐ There is a risk of inappropriate sexual behavior ☐ There is a risk of violent or self injurious behavior ☐ Symptom management difficulties(ability to manage psychiatric symptoms in their environment) ☐ Other behavioral management problem in the community ☐ Recent hospitalization/risk of hospitalization.	
2. Safety:	
Prompts: ☐ Lack of ability to responds to emergencies ☐ Structural, physical, or environmental barriers present concerns for well being of consumer ☐ Requires life support ☐ Requires a personal emergency response system ☐ Victimization	

Primary Categories	*Narrative*
This box is used for Supported Living requests: Only check the box that is relevant to the current request ☐ Safety plan for persons meeting intense criteria that do not require 1-1 for 24 hours ☐ Transition Plan to provide less than 1-1 Intense Supported living and move participant from Intense to High Support (can be authorized for up to one (1) year. ☐ Safety Plan to maintain participant with High Support (can be authorized following the completion of the Transition Plan).	The Safety Plan must be detailed, specific to the participant and include the following elements: 1. What are the risks? 2. Describe how the safety plan will reduce the risk to self and/or others allowing the participant to less that 1-1 staffing during a 24 hour day? 3. What are the scheduled staffing ratios specific to the participant for the typical calendar week? Include an activity schedule to support the staffing ratios for this participant. The Transition Plan must be detailed, specific to the participant, and include the following elements: 1. What are the risks? 2. Describe how the risk issues affect safety to self an/or others. 3. What is the plan to fade 24 hr/day 1-1 staff? 4. What is the back up plan to assure safety when 1-1 is not being provided? 5. What is the scheduled staffing ration specific to the participant for a typical calendar week? Include an activity schedule to support the staffing ratios for this participant. The Safety Plan must be detailed, specific to the participant, and include the following elements: 1. What are the risks? 2. Describe how the safety plan has reduced the risk to self and/or others allowing the participant to move from Intense to High Support. Include progress notes and data. 3. What is the scheduled staffing ratio specific to the participant for a typical calendar week?
3. Residential Services for Adults with Developmental Disabilities: Prompts: ☐ The participant requires 24 hour support in their home ☐ Lower cost alternatives to the frequency and type are not available ☐ Alternatives that would allow the participant to function with reduced or no supports for part of the day have been exhausted ☐ Other	
4. Risk for Deterioration or Loss of	

Primary Categories	***Narrative***
Skills: Prompts: ☐ Reduction of services would result in reduced independence or loss of skills ☐ Reduction of services would result in symptoms or conditions worsening ☐ Reduction of services may lead to a more restrictive environment ☐ Validate how this deterioration or loss of skills has been shown. ☐ Other	
5. Functional Limitations: Prompts: ☐ Self Care – Basic living skills ☐ Ability to understand ☐ Ability to communicate ☐ Learning ☐ Mobility ☐ Self-Direction ☐ Economic Self – Sufficiency ☐ Housing ☐ Employment ☐ Other	
6. Medical or Physical Conditions:	

Primary Categories	***Narrative***
Prompts: ☐ Confirm that the medical or physical condition requires continued treatment or follow-up and has significant impact on the individuals functioning. ☐ Confirm that the ability to function at a normal level is decreased because of frequent exacerbations of medical or physical conditions. ☐ Confirm that the functioning level of the individual is lower than the cognitive level would indicate because of the physical or medical condition. ☐ Other	

7. Significant Co-Occurring Disorders: DD - Mental Retardation/Psychiatric; Mental Retardation/Substance Abuse MH - Psychiatric/Medical; Psychiatric/Substance Abuse; Psychiatric/Mental Retardation	
Prompts: ☐ Confirm that the co-occurring disorder would indicate a higher level of care than either one alone. ☐ Other	
8. Court-Ordered Treatment:	
Prompts: ☐ Court-ordered treatment. ☐ Outpatient commitment ☐ Treatment necessary to meet other conditions stipulated by the court.	
9. Homelessness:	
Prompts: ☐ History of evictions ☐ Unable to maintain housing ☐ Other	

Additional information has been submitted with this form.

☐ Yes ☐ No

DD AND ISSH WAIVER SERVICES	PROCEDURE CODE & MODIFIER(S)	MEDICAID REIMBURSEMENT RATE
1. RESIDENTIAL HABILITATION – Supported Living		
A. Individual supported living services – individual or group living arrangement – 1 to 3 participants.	**H2015-U8**	$12.96/Hr. 1 unit = 15 minutes; 1 unit = $3.24 (24 hour/day unavailable under hourly services)
B. Group supported living services – group living arrangement- 2 or 3 participants.	**H2015-U8 HQ**	$7.64. Hr. 1 unit = 15 minutes; 1 unit = $1.91 (24 hour/day unavailable under hourly services
C. Daily supported living services: a. **High Support:** Persons must meet the SIB-R Support levels of Pervasive, Extensive or Frequent b. **Intense Support:** Persons require intense one-on-one supports. Evaluation is case by case using the intense support criteria. c. **School Based Services High Support:** **School days** **Non-School Days** d. **School Based Services Intense Support:** School days Non-School Days .	**H2022** **H2016-U8** **H2016** **H2022** **H2016** **H2016**	Blended staff - $225.32/Day 1 unit = 1 day 24 hours/day supported living service 1:1 Staff - $268.36/Day 1 unit = 1 day – Requires PA 24 hours/day supported living service Blended staff - $178.33/Day 1 unit = 1 day Requires PA Blended staff - $225.32/Day 1 unit = 1 day Requires PA 1:1 Staff - $212.46/Day 1 unit = 1 day Requires PA 1:1 Staff - $268.36/Day 1 unit = 1 day Requires PA
2. RESIDENTIAL HABILITATION AGENCY AFFILIATION FOR CFH		
A. Agency affiliated with a single Certified Family Home (CFH) with 1-4 participants	**0919B**	$7.96 /Day 1 unit = 1 day - per participant
B. CFH provider affiliated with a Residential Habilitation agency; the rate paid to the CFH provider	**S5140-U8**	$53.39/Day 1 unit = 1 day – per participant

for each participant living in the Certified Family Home.		
3. CHORE SERVICES: Skilled	**S5121-U8**	Lowest of (3) three competitive bids. PAC 5 – manually priced
4. RESPITE CARE:	**T1005-U8** **S9125-U8**	$8.48/Hr. Limited to 6 hours or 24 units per day; 1 unit = 15 minutes; 1 unit = $2.12 per unit $53.39/Day – Maximum
5. SUPPORTED EMPLOYMENT: Limited to 40 hrs per week maximum in combination with Developmental and Occupational Therapy, IBI, or Adult Day Care	**H2023-U8**	$21.00/Hr. 1 unit = 15 minutes; 1 unit = $5.25 Max 160 units per week
6. NON-MEDICAL TRANSPORTATION:	**A0080-U8**	$.44/mile per person provided by an agency $.10/mile per vehicle provided by an individual Limited to 1,800 miles per ISP year
7. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS:	**S5165-U8**	Actual cost or lowest of (3) three competitive bids for items over $500.00 (including labor)
8. SPECIALIZED MEDICAL EQUIPMENT: Ramps, environmental control such as switches to open door and wheelchair lifts.	**E1399-U8**	75% of vendor's retail price.
9. PERSONAL EMERGENCY RESPONSE SYSTEM:	**S5160-U8** **S5161-U8**	Installation One time per consumer, per residence; includes first month of service fee. Approximately $34.35/Month
10. HOME DELIVERED MEALS:	**S5170-U8**	$5.23/meal Limited to two (2) meals per day (14 meals per week)
11. NURSING SERVICES: Nursing Oversight – assessment/evaluation, training and supervision of nursing services provided by Res Hab or other Medicaid providers. Skilled Nursing Services – services that require technical or professional licensed personnel.	**T1001-U8 TD** **T1001 U8 TD** **T1001 U8** **T1000-U8**	**Nursing Oversight:** $35.59/Visit - Independent RN $44/49/Visit - Agency RN $35.59/Visit - RN oversight of LPN visits **Skilled Nursing Services:**

		$24.48/Hr. - Independent RN 1 unit = 15 minutes; 1 unit = $6.12
	T1000 U8 TE	$20.80/Hr. Agency LPN 1 unit = 15 minutes; 1 unit = $5.20
	T1000 U8 TD	$30.60/Hr. - Agency RN 1 unit = 15 minutes: 1 unit =$7.65
12. BEHAVIOR CONSULTATION / CRISIS MANAGEMENT:	**H2019-U8-U1**	Psychiatric Consultation Psychiatrist - $40.08/Hr. 1 unit = 15 minutes; 1 unit = $10.02
	H2019 –U8	QMRP/Clinician - $25.68/Hr. 1 unit = 15 minutes; 1 unit = $6.42
	H2019-U8 HM	Behavioral Consultation Emergency Intervention Tech - $11.60/Hr. 1 unit = 15 minutes; 1 unit = $2.90 Limited to 96 units per month.
13. ADULT DAY CARE: Limited to 30 hours per week as a single service or 30 hours per week maximum in combination with Developmental and Occupational Therapy	**S5100-U8**	$6.00/Hr.; 1 unit = 15 minutes; 1 unit = $1.50 Max 30 hrs per wk.
STATE PLAN SERVICES	**NEW PROCEDURE CODE**	**MEDICAID REIMBURSEMENT RATE**
1. MEDICAL REPORT BASED ON EXAM WITH THE PARTICIPANT	**99450**	$45.13 for each report
2. MEDICAL REPORT BASED ON PAST RECORD	**99080**	$10.38 for each report (effective 7/1/04)
3. PLAN DEVELOPMENT	**G9007**	1 unit = 15 minutes; 1 unit = $10.00 Limited to 12 hours per year
4. PLAN MONITORING	**G9012**	1 unit = 15 minutes: 1 unit = $10.00 Limited to 8 hours per year
5. TSC ONGOING		
a. 1st Six Months	**G9001**	$129.81/Month - 1st six months

b. After Six Months	**G9002**	$108.33/Month - after 1st six months
6. DEVELOPMENTAL THERAPY – Limitations: 30 hours per week as a single service or in combination with Occupational Therapy, Intensive Behavioral Intervention, Physical Therapy, Speech Therapy, and Psychotherapy.	**H 2032** **H2032 HQ** **97537** **97537 HQ** **H2000**	$18.12/Hr. – Center Individual; 1 unit = 15 minutes; 1 unit = $4.53 $7.20/Hr. – Center Group; 1 unit = 15 minutes; 1 unit = $1.80 $20.04/Hr. – Home/Comm. Individual; 1 unit = 15 minutes; 1 unit = $5.01 $8.56/Hr. – Home/Comm. Group; 1 unit = 15 minutes; 1 unit = $2.14 $18.12/Hr. – Evaluation; 1 unit = 15 minutes; 1 unit =$4.53
7. PHYSICAL THERAPY provided by DDA– Limitations: More than 25 visits per calendar year requires prior authorization by central office Medicaid staff. (Counts toward the 30 hour per week limitation on DDA therapy services).	**97110** **97150 HQ** **97001**	$56.00/Hr. - Individual; 1 unit = 15 minutes; 1 unit = $14.00 $14.36/Hr. - Group; 1 unit = 15 minutes; 1 unit = $3.59 $56.00/Hr. - Evaluation; 1 unit = 15 minutes; 1 unit = $14.00
8. SPEECH THERAPY provided by a DDA – Limitations: 250 visits maximum per calendar year. (Counts toward the 30 hour per week limitation on DDA therapy services). **Speech and Hearing evaluation combined**	**92507** **92508** **92506**	$56.00/Hr. - Individual; 1 unit = 15 minutes; 1 unit = $14.00 $17.48/Hr. - Group; 1 unit = 15 minutes; 1 unit = $4.37 $56.00/Hr. - Evaluation; 1 unit = 15 minutes; 1 unit = $14.00
9. OCCUPATIONAL THERAPY: Limitation: 30 hours a week as a single service or in combination with	**97535**	$56.00/Hr. - Individual; 1 unit = 15 minutes; 1 unit = $14.00

Developmental Therapy Intensive Behavioral Intervention, physical therapy, speech therapy, and psychotherapy.	**97535 HQ** **97003**	 $14.36/Hr. - Group; 1 unit = 15 minutes; 1 unit = $3.59 $56.00/Hr. – Evaluation; 1 unit = 15 minutes; 1 unit = $14.00
10. PSYCHOTHERAPY, in a DDA: Limitation: <u>45 hours per year</u>, alone or in combination with Supportive Counseling. (Counts toward the 30 hour per week limitation on DDA therapy services). **1. Individual Medical Psychotherapy** **2. Group Medical Psychotherapy** **3. Family Medical Psychotherapy** **4. Psychiatric Diagnostic Interview and Exam** **5. Psychological testing for diagnosis and evaluation**	**H0004** **90853** **90847** **90801** **96101** **96102** **96103**	 $57.40/Hr. - Individual; 1 unit = 15 minutes; 1 unit = $14.35 $15.56/Hr. - Group; 1 unit = 15 minutes; 1 unit = $3.89 $51.36/Hr. - Family; 1 unit = 15 minutes; 1 unit = $12.84 $65.84/Hr. –Evaluation. 1 unit = 15 minutes; 1 unit = $16.46 Administered by a licensed psychologist or physician. 1 unit = 1 hour 1 unit = $59.32 Administered by a technician (See IR- MA06-10 dated 4/7/06 for complete definition). 1 unit = 1 hour $41.70. Administered by a computer, with professional interpretation and report. $25.99 per assessment report.
11. SUPPORTIVE COUNSELING in a DDA: Limitation: <u>45 hours per year</u>, alone or in combination with Psychotherapy. (Counts toward the 30 hour per week limitation on DDA therapy services).	**H0004 HM**	$32.00/Hr. – 1 unit = 15 minutes; 1 unit = $8.00.
12. PHARMACOLOGICAL MANAGEMENT – including prescription use and review of medication with no more than minimal psychotherapy.	**90862**	1 unit = 1 visit 1 unit $50.26
13. SOCIAL HISTORY	**T1028**	$39.76/Hr. – 1 unit = 15 minutes; 1 unit = $9.94

14. COLLATERAL CONTACT	**90887**	$39.76/Hr. - 1 unit = 15 minutes; 1 unit = $9.94
15. MEDICAL TRANSPORTATION	**S0215** **S0215 TF**	$.44/mile – agency (21 miles or more requires Medical Transportation Unit PA) $.10 – individual (Prior authorized if over 400 miles)
16. INTERPRETATION – DEAF OR FOREIGN LANGUAGE (Payment for foreign language and signing)	**8296A**	$12.16/Hr. - 1 unit = 1 hour
17. COMMUNITY CRISIS SERVICES Limited to a maximum of (20) hours per crisis for a period of (5) consecutive days	**H2011**	Crisis Intervention Service; 1 unit = 15 minutes; 1 unit = $11.35
18. MENTAL HEALTH SERVICE a. Interactive Medical Psychiatric Diagnostic interview:	**90801**	1 unit = 15 minutes 1 unit = $37.04 MD with U1 modifier 1 unit = $16.46 Other per unit
b. Psychological testing for diagnosis and evaluation	**96101**	Administered by a licensed psychologist or physician. 1 unit = 1 hour 1 unit = $59.32
	96102	Administered by a technician (See IR- MA06-10 dated 4/7/06 for complete definition). 1 unit = 1 hour $41.70.
	96103	Administered by a computer, with professional interpretation and report. $25.99 per assessment report.
c. Individual Psychotherapy	**90804** **90806** **90808**	20-30 minutes = $62.92 MD w/UA mod. $38.37 other 40-50 minutes = $94.41 MD w/UA mod. $57.57 other 75-80 minutes = $140.81 MD w/UA mod. $85.86 other
d. Group Psychotherapy:	**90853** **90853 U4**	1 unit = 15 minutes 1 unit = $8.44 MD w/U1 Mod. 1 unit = $3.89 other 1 unit = $3.89 (N.F.)

e. Partial Care: Skills training and development	**H2014**	1 unit = 15 minutes 1 unit = $2.44
f. Pharmacologic Management: including prescription, use, and review of medication with no more than minimal psychotherapy.	**90862**	1 unit = 1 visit 1 unit = $50.26/visit
g. Individual Psychosocial Rehabilitation	**H2017**	1 unit = 15 minute 1 unit = $11.35
h. Group Psychosocial Rehabilitation	**H2014 HQ** **(modifier required)**	1unit = 15 minutes 1 unit = $2.77

DEFINITIONS

Abuse. Any conduct of an employee, affiliated residential habilitation provider or contractor of an agency as a result of which a person suffers verbal aggression or humiliation, skin bruising, bleeding, malnutrition, sexual molestation, burns, fracture of any bone, subdural hematoma, soft tissue swelling, failure to thrive or death, or mental injury, and such condition or death is not justifiably explained, or where the history given concerning such condition or death, or the circumstances indicate that such condition or death, may not be the product of accidental occurrence under Section 39-5202, Idaho Code.

Adult. A person who is eighteen (18) years of age or older or an ISSH Waiver participant.

Administrator. The individual who is vested with primary responsibility for the direction and control of an agency, and who has power to legally bind the agency to contracts.

Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a person with developmental disabilities. A participant may act as his own advocate

Appeal. A method to insure personal, civil and human rights by receiving, investigating, resolving, and documenting complaints related to the provision or termination of services of the residential habilitation services agency in accordance with IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings”.

Audit. A methodical examination and review.

Baseline Statement: An assessment of performance under natural conditions before instruction occurs. The baseline describes the level of a skill or behavior before intervention to modify it.

Board. The Idaho State Board of Health and Welfare.

Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services.

Budget. The level of financial support that corresponds to a participant’s assessed needs, level of support determined by the SIB-R, and the past three (3) years’ expenditures, when available. Using this information, the budget is negotiated with the plan developer, the participant, and the assessor

Business Entity. A public or private organization owned or operated by one (1) or more persons.

Certificate. A permit to operate a residential habilitation agency.

Certifying Agency. Regional units of the Department that conduct inspections and surveys and issue certificates based on the residential habilitation agency’s compliance with this chapter.

Chemical Restraint. The use of any medication that results or is intended to result in the modification of behavior without an accompanying behavior management program.

Clinical Review. A process of professional review that validates the need for continued services.

Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies.

Complaint Investigation. An investigation of an agency to determine the validity of an allegation against it and to identify solutions to resolve conflicts between the complainant and the agency.

Concurrent Review. A clinical review to determine the need for continued prior authorization of services.

Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: **a.** Hospitalization; **b.** Loss of housing; **c.** Loss of employment or major source of income; **d.** Incarceration; or **e.** Physical harm to self or others, including family altercation or psychiatric relapse.

Crisis Service Coordination. Crisis service coordination services are linking, coordinating and advocacy services provided to assist a participant to access emergency community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services.

Customer. Any stakeholder with the exception of the participant.

Current Assessment. An assessment that accurately reflects the status of the participant.

Deficiency. A determination of non-compliance with a specific rule or part of a rule.

Department. The Idaho Department of Health and Welfare.

Developmental Disability. A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person that appears before the age of twenty-two (22) years of age and: **a.** Is attributable to an impairment, such as mental retardation, cerebral palsy, epilepsy, autism or other conditions found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; and **b.** Results in substantial functional limitations in three (3) or more of the following areas of major life activity: i. Self-care; ii. Receptive and expressive language; iii. Learning; iv. Mobility; v. Self-direction; vi. Capacity for independent living; or vii. Economic self-sufficiency; and **c.** Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of life-long or extended duration and individually planned and coordinated.

Director. Director of the Idaho Department of Health and Welfare or his designee.

Exception Review. A clinical review of a plan that falls outside the established standards.

Exploitation. An action which may include the misuse of a vulnerable participant's funds, property, services, or resources by another person for profit or advantage.

Full Certificate. A certificate issued by the Department to residential habilitation and service coordination agencies.

Goal The desired outcome related to an identified issue

Goal (long term) Broad in nature, long term goals are used to guide the development of goals to be addressed within the plan year on the ISP Supports and Services page.

Goal (short term) An objective that is attainable in a short amount of time and is placed on the ISP Supports and Services page.

Governing Authority. The designated person or persons who assume full responsibility for the conduct and operations of the residential habilitation services agency.

Government Unit. The state, or any county, municipality, or other political subdivision, or any department, division, board or other agency thereof.

Guardian. A legally-appointed person who has the care of the person or property of another, under Section 66-404, Idaho Code.

High Cost Services. High cost services are medical services that result in expensive claims payment or significant state general fund expenditure that may include: **a.** Emergency room visits or procedures; **b.** Inpatient medical and

psychiatric services; **c.** Nursing home admission and treatment; **d.** Institutional care in jail or prison; **e.** State, local, or county hospital treatment for acute or chronic illness; and **f.** Outpatient hospital services.

Human Services Field. A particular area of academic study in health, social services, education, behavioral science or counseling.

Implementation Plan. Written documentation of participants' needs, desires, goals and measurable objectives, including documentation of planning, ongoing evaluation, data-based progress and participant satisfaction of the program developed, implemented, and provided by the agency specific to the plan of service.

Interdisciplinary Team. A team of professionals, determined by the Department, that reviews requests for reconsideration.

Intermediate Care Facility for Persons With Mental Retardation (ICF/MR). An intermediate care facility whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with mental retardation or persons with related conditions.

Level of Support. An assessment score derived from the SIB-R that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community.

Measurable Objective. A statement which specifically describes the skill to be acquired or service/support to be provided, includes quantifiable criteria for determining progress towards and attainment of the service, support or skill, and identifies a projected date of attainment.

Mechanical Restraint. Any device that the participant cannot remove easily that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body or environment. Excluded are devices used to achieve proper body position, balance, or alignment.

Medical Necessity. A service is medically necessary if: **a.** It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and **b.** There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly. **c.** Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

Medication. Any substance or drug used to treat a disease, condition or symptoms which may be taken orally, injected or used externally and is available through prescription or over-the-counter.

Neglect. The negligent failure to provide those goods or services which are reasonably necessary to sustain the life and health of a person under Section 39-5302 (8), Idaho Code.

Objective A milestone towards meeting the goal that is concrete, measurable, time-limited, and behaviorally specific.

Outcome-Based Review. An on-site review conducted by a trained reviewer authorized by the Department to determine participant satisfaction with the services received and improvement or impact upon his lifestyle following implementation of the plan of service.

Paraprofessional. An adult who has a minimum of a bachelor's degree in a human services field but no experience with participants, or a person without a degree but with a high school diploma or equivalency who has at least twelve (12) months' experience with the population to whom they will be providing services.

Participant. A person who is eligible for Medicaid, receives health care services and/or state plan and/or waiver services.

Person-Centered Planning Process. A meeting facilitated by the plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service.

Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process.

Physical Restraint. Any manual method that restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body. Excluded are physical guidance and prompting techniques of brief duration.

Physician. Any person licensed as required by Title 54, Chapter 18, Idaho Code.

Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process.

Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. The plan developer is the plan monitor unless there is a Service Coordinator, in which case the Service Coordinator assumes both roles.

Plan Monitor Summary. A summary that provides information to evaluate plans and initiate action to resolve any concerns. The plan monitor must complete a plan monitor summary when the plan has been in effect for six (6) months and at the annual person-centered planning process. The summary is based on the provider status reviews. The plan monitor will use the provider information to evaluate plans and initiate action to resolve any concerns.

Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days.

Practitioner of the Healing Arts. A Physician, Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist.

Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules.

Progress Note. A written notation, dated and signed by a member of the person-centered planning team or service provider, that documents facts about the participant's assessment, services provided, and the participant's response during a given period of time.

Provider. Any individual, organization or business entity furnishing medical goods or services who has applied for and received a provider number and entered into a written provider agreement, under IDAPA 16.03.09 "Rules Governing the Medical Assistance Program," Sections 020 and 040.

Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service.

Psychosocial Information. A combined summary of psychological and social histories of a participant designed to provide the person-centered planning team with an accurate reflection of the participant's current skills, abilities, and needs.

Punishment. Any procedure in which an adverse consequence is presented that is designed to produce a decrease in the rate, intensity, duration or probability of the occurrence of a behavior; or the administration of any noxious or unpleasant stimulus or deprivation of a participant's rights or freedom for the purpose of reducing the rate, intensity, duration, or probability of a particular behavior.

QMRP. Qualified Mental Retardation Professional as defined in 42 CFR 483.430.

Residential Habilitation. Services consisting of an integrated array of individually-tailored services and supports furnished to an eligible participant which are designed to assist them to reside successfully in their own homes, with their families, or alternate family home.

Reviewer. A person or other entity authorized by the Department to conduct reviews to determine compliance with the program requirements and participant satisfaction with the services.

Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement.

Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence.

Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment.

Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant.

Rule. A requirement established by state, federal, or local government under the law and having the effect of law.

SIB-R. The Scales of Independent Behavior - Revised (SIB-R) is a standardized assessment tool evaluating functional skill levels and evaluating maladaptive behavior. The SIB-R is used by the Department or its designee to determine waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant budget.

Seclusionary Time Out. The contingent removal of an individual from a setting in which reinforcement is occurring that is designed to result in a decrease in the rate, intensity, duration or probability of the occurrence of a response, and entails the removal of the individual to an isolated setting.

Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements of a Service Coordinator as defined in IDAPA Rules. Service coordinators help participants find Medicaid and non-Medicaid supports, services and community resources for their needs to live in the community. They monitor and coordinate Medicaid services to assure non-duplication between services and participant satisfaction of services.

Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community.

State Plan Services Services available to those who qualify such as Service Coordination, Plan Development, Plan Monitoring, Developmental Therapy, Community Crisis Supports, Medical Transportation, Durable Medical Equipment, Occupational Therapy, Speech Therapy, Physical Therapy, and Psychotherapy.

Substantial Compliance. An agency is in substantial compliance with these rules when there are no deficiencies which would endanger the health, safety or welfare of the participants.

Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function or activity.

Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of his choice.

Supports (formal). Services that are paid and have behavioral objectives (i.e. supported living, DDA, or CSE).

Supports (informal). Services that are paid but do not have behavioral objectives (i.e. transportation, DME, etc.).

Supports (natural). Activities that are not paid and do not have behavioral objectives (i.e. attend church with family member, play cards with neighbor, attend Special Olympics, participate in recreational activities, etc.).

Transition Plan. An interim plan developed by the residential habilitation agency defining activities to assist the participant to transition out of residential habilitation services from that agency.

Waiver Services. Individually tailored services and supports as amended under Waiver Number 0076.90 (B) provided by an agency to an eligible recipient to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage choice, and to achieve and maintain community integration and participation.

DDA SERVICE MIX

Due to unforeseen circumstances, an individual's specific needs for group and individual developmental therapy may vary from what was authorized on an ISP. To accommodate these circumstances, a DDA is allowed to adjust the manner in which the total number of hours of group and individual developmental therapy are being provided within the authorized service mix. Circumstances which could contribute to a need for flexibility around the type and amount of group and individual developmental therapy could include illness, increased behavior concerns, transportation issues, etc.

When a DDA finds it needs to adjust the type and amount of developmental therapy identified on the plan, the change and reason for the adjustment(s) must be thoroughly documented in the individual's agency file.

IMPORTANT NOTE: Although flexibility around the mix of group versus individual developmental therapy is allowed, the total number of hours authorized for developmental therapy in a given week is not flexible. A DDA may not submit a claim for more hours than what is authorized for a given week.

In addition, it is essential that a DDA track utilization of each type and amount of developmental therapy provided within the service mix (individual versus group).

If the circumstance(s) requiring an adjustment of the service mix continue for an indefinite period of time, the cost of DDA services, as initially negotiated on a plan, could end up exceeding the original amount. If so, it is the responsibility of the DDA to ask the Plan Developer to initiate an Addendum requesting additional DDA service hours. That is why tracking of utilization of each type and amount of developmental therapy is so important.

It is also imperative that the Addendum request be made in a timely fashion to avoid a lapse in DDA service delivery to the participant. A justification as to why the service hours were depleted must also accompany the Addendum.